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A CASE PRESENTATION ON CHRONIC ALCOHOLIC LIVER DISORDER

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ABSTRACT :

Alcoholic liver disease refers to the liver damage caused by excessive alcohol consumption. It includes conditions ranging from fatty liver to alcoholic hepatitis and cirrhosis. The key functions of the liver are detoxification, metabolism, digestion, and maintaining overall homeostasis. There are several causes, such as alcohol consumption, obesity, diabetes, high cholesterol, and hepatic infections. Some genetic disorders, like hemochromatosis and Wilson's disease, also cause ALD. There are usually five stages of liver damage, starting from fatty liver and ranging to hepatitis, fibrosis, cirrhosis, and then hepatic cellular carcinoma (liver failure).

INTRODUCTION:

Alcoholic liver disease is a progressive inflammatory liver injury caused by excessive alcohol intake.
Alcoholic liver disorder is a progressive inflammatory liver injury caused by long-term alcohol consumption. Of all chronic drinkers, about 50-20% of the population develops hepatitis and cirrhosis, which can be reversible upon alcohol abstinence. Alcoholic liver disorder usually persists and progresses to cirrhosis if alcohol use continues.

ETIOPATHOGENESIS :

When up to 80 grams of alcohol are consumed over a period of one to several days, mild, reversible hepatic steatosis is typically the result. The risk of severe hepatic injury is greatly increased by consuming 80 grams or more of ethanol per day, and serious injury is caused by consuming 160 grams or more of ethanol per day for 10 to 20 years. Three levels of manifestation are described. .

1. Fatty liver, or hepatocellular steatosis: This is the first condition brought on by moderate alcohol use. Lipid droplets build up in the hepatocyte cells under this situation, and eventually the tiny droplets combine to form larger ones.On a macroscopic level, the fatty liver of people with chronic drinking is a big, squishy, yellow, and oily organ that weighs 4 to 6 kg. Fatty change is completely reversible if there is abstention from further intake of alcohol.
2. Hepatocyte swelling and necrosis are hallmarks of alcohol-induced hepatitis. The buildup of water and fat, along with proteins that are typically exported, causes the edema. Denk-Mallory bodies: These typically appear in enlarged hepatocytes as clumped, amorphous, eosinophilic debris. Since they are also present in non-alcoholic fatty liver disease, it is not a characteristic exclusive to alcoholic liver disease. The hepatic lobule is penetrated by neutrophils, which then gather around hepatocytes that are degenerating, especially those with Mallory-Denk bodies. Alcoholic steatofibrosis (cirrhosis): Alcoholic hepatitis is often accompanied by prominent activation of sinusoidal stellate cells and portal areas. Fibrosis begins with sclerosis of Central veins.

CLINICAL MANIFESTATION:

- . Abdominal pain
- . Jaundice
- . Hematological disorders
- . Indigestion and constipation
- . Fainting and mental disturbance
- . Renal disorder

CASE STUDY :

A male patient aged 53 years came to the hospital with complaints of fever for the past week, low-grade and associated with chills that were relieved by medication, a dry cough for one week, and loose stools for two days with 3 to 4 watery episodes. He has also experienced vomiting for two days, abdominal distention for four months, yellowish discoloration of the eyes, itching of the skin, decreased urine output, and abdominal pain since yesterday.
Social history: Chronic alcoholic for 30 years, consuming 180 to 250 ml/day of whisky.
Tobacco chewing for 30 years, consuming one packet/day of Ambar.

LIFESTYLE MODIFICATIONS:

1. Alcohol Abstinence: Complete cessation of alcohol is the most critical step, supported by medical counseling (Naltrexone, Acamprosate, Disulfiram).
2. Healthy diet: A high-protein, high-calorie diet to prevent malnutrition. Include vegetables, fruits, whole grains, and lean proteins (chicken, fish, legumes). Avoid processed foods, excessive sugar, and saturated fats.
3. Hydration: Drink plenty of water to support liver function. Avoid sugary and carbonated beverages.
4. Exercise and weight management: Engage in moderate exercise (walking, yoga, strength training) to maintain a healthy weight. Avoid rapid weight loss, as it may worsen liver damage.
5. Smoking cessation: Smoking increases the risk of liver cancer, and women with ALD should seek help to quit.
6. Medication awareness: Avoid NSAIDs (ibuprofen, aspirin) and limit acetaminophen (Paracetamol) unless prescribed.
7. Regular medical checkups: Monitor liver function with regular blood tests and imaging (Ultrasound, Fibro Scan).

CONCLUSION :

In the above case study, the patient presented with chief complaints of high-grade fever, loose stools, vomiting, jaundice, decreased urine output, and abdominal distension for 4 months. The patient underwent some laboratory tests in which LFT results were abnormal. Based on the above symptoms and laboratory tests, the patient was diagnosed with Decompensated Alcoholic Liver Disease. The patient was prescribed medications for relief and to promote liver regeneration. Lifestyle modifications may also help to relieve the symptoms and promote healthy liver functioning